



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA ROAD
PASADENA TX 77504

Respondent Name

OLD REPUBLIC INSURANCE CO

Carrier's Austin Representative Box

44

MFDR Tracking Number

M4-09-7322-01

MFDR Date Received

MARCH 30, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Provider submitted its bill to Carrier on April 16, 2008 including required reports and implant invoices. On or about May 14, Carrier sent provider an Explanation of Benefits and included payment in the amount of \$26,711.48. On November 21, 2008, provider sent Carrier a Request for Reconsideration noting that Carrier failed to reimburse Provider pursuant to the appropriate sections of the fee guideline applicable when Provider requests separate reimbursement for implantables, specifically, 28 TEX. ADMIN. CODE section 134.404(f)(1). On or about March 05, 2009, Carrier sent provider an Explanation of Benefits and included payment in the amount of \$132.00 after reconsideration. Carrier's payment of \$26,711.48 is...less than the amount that Vista should have been reimbursed if it had not requested implantables be reimbursed separately under 134.404(f)(1)(B), specifically, \$65,177.57. It is unclear what methodology Carrier used to calculate reimbursement, but it is clear that the amount reimbursed is insufficient under the Fee Guideline. With regard to the charges at issue in this dispute, there is no evidence presented by the Carrier that the prices billed were not Provider's usual and customary charges...or that the final price was not fair and reasonable. Therefore, the Carrier is required to reimburse Provider **\$65,711.57** pursuant to the Inpatient Fee guideline, which will result in fair and reasonable reimbursement for the services provided to the injured worker. The Carrier made a partial payment of **\$26,711.48**. Therefore, the Carrier is required to reimburse Provider in the amount of **\$38,466.09**, plus any and all applicable interest..."

Amount in Dispute: \$38,466.09

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...the Provider has not timely submitted this MDR Request. Respondent asserts it paid more than a fair and reasonable rate to the Requestor for all services rendered to the claimant...Respondent seeks a finding that Requestor is due no further funds as the MDR Request was not timely submitted."

Response Submitted by: Harris & Harris, 5900 Southwest Parkway, Building 2, Austin, TX 78735

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 27, 2008 Through March 29, 2008	Inpatient Hospital Surgical Services	\$38,466.09	\$38,466.09

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services effective March 1, 2008.
3. 28 Texas Administrative Code §102.3 sets out guidelines for computation of time.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated May 14, 2008

- ***No reason codes listed on Explanation of Benefits.

Explanation of benefits dated February 24, 2009

- M – Payment recommended at fair and reasonable rate.
- F – Reimbursement has been based on the average wholesale price plus a mark-up and dispensing fee.

Issues

1. Was the dispute submitted timely to Medical Fee Dispute Resolution?
2. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
3. Which reimbursement calculation applies to the services in dispute?
4. What is the maximum allowable reimbursement for the services in dispute?
5. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. Division rule at 28 Texas Administrative Code §133.307(c) states, "Requests. Requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. Requestors shall file two legible copies of the request with the Division.
(1) Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request.
(A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (b) Of this paragraph shall be filed no later than one year after the date(s) of services in dispute.

Texas Government Code §311.005 *GENERAL DEFINITIONS* states "The following definitions apply unless the statute or context in which the work or phrase is used requires a different definition: (12) 'Year' means 12 consecutive months."

Division rule at 28 Texas Administrative Code §102.3 states

"(a) Due dates and time periods under this Act shall be computed as follows:

- (1) computing a period of days. In counting a period of time measured by days, the first day is excluded and the last day is included.
- (2) Computing a period of months. If a number of months is to be computed by counting the months from a particular day, the period ends on the same numerical day in the concluding month as the day of the month from which the computation is begun, unless there are not that many days in the concluding month, in which case the period ends on the last day of that month.
- (3) Unless otherwise specified, if the last day of any period is not a working day, the period is extended to include the next day that is a working day.

(b) A working day is any day, Monday-Friday, other than a national holiday as defined by Texas Government Code §662.993(A) and the Friday after Thanksgiving Day, December 24th and December 26th. Use in the title of the term 'day,' rather than 'working day' shall mean a calendar day.

The disputed dates of service are March 27, 2008, March 28, 2008 and March 29, 2008. In accordance with Division rule at 28 Texas Administrative Code §102.3 (a)(3), one year from disputed date of service March 27, 2008 was Saturday, March 28, 2009; one year from disputed date of service March 28, 2008 was Sunday,

March 29, 2009; and one year from disputed date of service March 29, 2008 was Monday March 30, 2009. In accordance with Division rule at 28 Texas Administrative Code §102.3 (a)(3), the next working day was March 30, 2009. The requestors DWC 60 request for medical fee dispute resolution was date stamp received by the Division on March 30, 2009. The Division finds that this dispute was filed timely and will be reviewed in accordance with the fee guideline in effect on the disputed dates of service.

2. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
 - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
 - (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

3. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
 - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
 - (A) 143 percent; unless
 - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

No documentation was found to support that the facility requested separate reimbursement for implantables in accordance with §134.404(g); for that reason the MAR is calculated according to §134.404(f)(1)(A).

4. 28 Texas Administrative Code §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at <http://www.cms.gov>. Documentation found supports that the DRG assigned to the services in dispute is 455, and that the services were provided at Vista Hospital of Dallas. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of \$86,230.77. This amount multiplied by 143% results in a MAR of \$123,310.00.
5. The division concludes that the total allowable reimbursement for the services in dispute is \$123,310.00. The respondent issued payment in the amount of \$26,843.48. Based upon the documentation submitted and the requestor's *Table of Disputed Services*, additional reimbursement in the amount of \$38,466.09 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$38,466.09 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

December 14, 2012
Date

Signature

Medical Fee Dispute Resolution Manager

December 14, 2012
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.